STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	10/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Investigation of Complaints IN00117302 and IN00117175. Complaint IN00117302 - Substantiated. Federal/state deficiencies related to the allegations are cited at F226, F309, F329, and F465. Complaint IN00117175 - Substantiated. Federal/state deficiencies related to the allegations are cited at F224, F226, F309, F314, F425, F431, F441, F465, and F518. Unrelated deficiency cited. Survey dates: October 10, 11, 15, 16, and 17, 2012 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Jennie Bartelt, RN, TC Debra Peyton, RN (October 10 and 11, 2012) Gwen Pumphrey, RN (October 10 and 11, 2012) Gordon Tyree, RN (October 10 and 11, 2012)	F0000	Submission of this plan of correction does not constitute an admission or agreement by Clark Rehabilitation and Skilled Nursing Facility of the facts alleged of conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are submitted and/or executed in compliance with state and federal laws.This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census bed type: SNF: 7 SNF/NF: 63 Total: 70 Census payor type: Medicare: 11 Medicaid: 51 Other: 8 Total: 70 Sample: 21 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 10/23/12 Cathy Emswiller RN			

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F0164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation and record review, the facility failed to ensure the resident's privacy during care for 6 of 10 residents observed during hands-on care in a sample of 21. (Residents U, K, A, J, I, and O) Findings include:	F0164	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Privacy curtains, window curtains/blinds, and doors closed to ensure privacy is afforded to residents during care. Residents covered so as to not be left fully exposed while care	11/16/2012

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	1. On 10/10/12 at 5:10 a.m., CNA #18 was observed providing incontinent care for Resident U. Resident U was lying in her bed. CNA #18 did not pull the curtain between the beds or Resident U and her roommate, who was also lying in bed. Resident U's bedcovers were removed, and the resident was left exposed from the waist down as CNA #18 moved away from the bed to locate and work with supplies for the care, and then as the CNA provided the incontinent care. 2. On 10/10/12 at 11:25 a.m., LPN #11 was observed completing a bolus gastrostomy tube feeding and site care for Resident K. Resident K was lying in bed with the head of the bed up. The bed curtain was not pulled around the resident. During the feeding, the resident's abdomen was exposed. The abdomen remained exposed during care of the gastrostomy tube site, and the resident's right breast was fully exposed. 3. On 10/10/10 at 3:05 p.m., CNA #14 was observed providing incontinent care for Resident A. The resident's room door was closed, and entry was allowed after knocking. The resident was lying in the room's second bed with CNA #14 on the far side of the bed. The curtain between the first and second beds was not pulled,		preparations are being made by staff.Residents U, K, A, J, I, and O did not have a negative outcome related to the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.Privacy curtains, window curtains/blinds, and doors closed to ensure privacy is afforded to residents during care. Residents covered so as to not be left fully exposed while care preparations are being made by staff.Nursing staff in-serviced on privacy/dignity by the SDC/designee-post test included.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**Nursing staff in-serviced on privacy/dignity by the SDC/designee-post test included.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to**	

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	and Resident A was exposed from the waist down. 4. On 10/11/12 at 12:10 p.m., LPN #15 was observed during wound care for Resident J. The resident's door was open to the hallway, and the bed curtain was not pulled around Resident J. LPN #15 exposed the resident's feet and began to provide care to the toes. During the care, CNA #16 approached the open door with a lunch tray and indicated, "Knock! Knock! Can I come in?" and entered the room. CNA #16 indicated she would return with the tray and indicated, "I'll pull this door to." The curtain was not pulled around the resident's bed as care continued. 5. On 10/15/12 at 10:55 a.m., CNAs #12 and #14 were observed providing incontinent care for Resident I. Resident I was lying in bed next to the window with the window curtains open to a view of the facility's glassed-in smoke shed used by residents. The room door was open. The bed curtain between the bed and room door was partially pulled. A CNA stood on each side of the bed. As the CNAs reached to remove the resident's bed covers, closing of the door and window curtains was requested and completed. The resident's bed covers were removed, and CNA #12 removed		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CQI tool for privacy/dignity will be utilized weekly x 4, monthly x 6 and quarterly thereafter during all 3 shifts.Findings from the CQI process will be reviewed monthly and an action plan will implemented as needed for any deficient practice below the 95% threshold.DNS/designeee is responsible to ensure compliance	

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	Resident I's gown, leaving the resident completely exposed from head to toe. The resident lay fully exposed while CNA #14 obtained a bag for soiled linens, returned to the bedside to dispose of the linens, and obtained cleansing supplies in the resident's bathroom. CNA #12 stood at the bedside during this time. The resident remained completely exposed from head to toe as incontinent care was provided. CNA #12 left the bedside, indicating she needed to help another resident. While the resident remained fully exposed, CNA #14 left the room to obtain linens. When care was complete, CNA #14 indicated to Resident I, "We'll get a gown and sheet on you." 6. On 10/16/12 at 1:20 p.m., CNAs #10 and #8 were observed providing incontinent care for Resident O. The resident was transferred by Hoyer lift from wheel chair to bed, and her pants were removed, exposing her brief and bare legs. While CNA #10 searched for supplies in the resident's bedside table and prepared a basin of water in the bathroom, the resident lay in bed with brief and bare legs fully exposed. CNA #8 remained at the resident's bedside during this time. The facility's "Skills Validation - CNA for Perineal Care" was provided by the Nurse Consultant on 10/15/12 at 1:00 p.m.			

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	Review of the document indicated, "Procedure Steps....2. Provide for privacy...." 3.1-3(p)(2) 3.1-3(p)(4)			

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F0224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure residents were protected from misappropriation of residents' money and medications for 4 of 4 residents reviewed related to misappropriation in a sample of 21. (Residents E, F, H, and M) Findings include: 1. During interview on 10/15/12 at 3:45 p.m., Resident F indicated a facility staff member had taken and cashed checks from the checkbook he kept in a tub on the overbed table next to his bed. The resident indicated his name and his deceased mother's name were on his bank account, and the staff member had made the checks out to himself and signed the mother's name. Resident F indicated he reported the incident to the facility, and action was taken right away. The resident indicated the bank put stop payment on the checks, and his money had been returned to his account. Resident F indicated the staff member would be prosecuted.	F0224	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Employees involved in the alleged misappropriations were suspended immediately and terminated after investigation was completed.Resident F's money was replaced to his accountResident E's money was replacedResident's H and M were not affected by the alleged deficient practice and recieved their medications as prescribed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.An audit of all personnel records conducted to ensure all required certification/licensure documents and background checks are present and accurate.All potential employees requiring certification/license will have proofverification of their certification/license evidenced by	11/16/2012

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	Review of the facility's file related to Resident F's stolen checks indicated the following: The resident became aware and reported the checks missing on 9/4/12 when the bank notified him his account was overdrawn. The checks appeared to be made out to a person whose name matched that of an employee at the facility. The employee was suspended pending investigation, and the police were notified and initiated an investigation. The attached police report indicated evidence gathered by police included video footage of a former employee who worked as a CNA (CNA #6) at the facility. The video showed the former employee cashing three checks for the amounts missing from Resident F's bank account. An affidavit for the arrest of CNA #6 had been submitted to the local county Prosecutor's office. The employee file for CNA #6 was reviewed on 10/11/12 at 9:55 a.m. The file indicated CNA #6 was hired on 7/24/12. The filed lacked documentation of CNA #6's certification or Nurse Aide Training in preparation for certification testing. During interview on 10/11/12 at 3:45 p.m., the Director of Nursing Services (DNS) indicated the facility had realized		a current copy of their certificate/license unless they are a c.n.a. awaiting testing. They then must provide proof of attendance in a c.n.a. class and will not be allowed to work with residents until this information is provided. Background checks will be completed for all potential employees. No one will be allowed to work without an approved background check. SDC and front office staff in-serviced 1:1 on necessary certification/licensure and background checks required for employee records prior to being hired.All staff in-serviced on abuse by the SDC/designee-post test included. Non-compliance with these practices will result in suspension pending investigation and possible termination for any alleged abuse.SDC and Executive Director/designee are responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All potential employees requiring certification/license will have proof/verification of their certification/licensure evidenced by a current copy of their certificate/license unless they are a c.n.a. awaiting testing. They then must provide proof of attendance in a c.n.a. class and will not be allowed to work with residents until this information is	

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	after this incident that not all employee files included appropriate screening of potential employees, including CNA certification. She indicated CNA #6 had not been checked for certification prior to employment. She indicated she had just phoned a Nurse Aide Trainer who told her CNA #6 "did have training, but did not show up for his test." Review of the facility's policy for Abuse Prohibition, Reporting, and Investigation, included in the file related to the misappropriation of Resident F's money, indicated, "1.American Senior Communities will not permit residents to be subjected to abuse by anyone.... 2. Employment screening is done on all potential employees to assure that the facility does not employ individuals...b. Who do not have current licensure or certification clear of findings concerning....misappropriation of resident property...." 2. During interview on 10/15/12 at 10:00 a.m., Resident E indicated she had three $1.00 bills and a $20.00 gift card stolen from her purse. She indicated she reported it, and the facility took action right away. She indicated she didn't know who the thief was, but she understood it was a staff person caught on camera spending the card. She indicated the		provided. Background checks will be completed for all potential employees. No one will be allowed to work without an approved background check. SDC and front office staff in-serviced 1:1 on necessary certification/licensure and background checks required for employee records prior to being hired.All staff in-serviced on abuse by the SDC/designee-post test included. Non-compliance with these practices will result in suspension pending investigation and possible termination for any alleged abuse.SDC and Executive Director/designee are responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI audit tool for employee records will be utilized for all new hiresCQI audit tool for abuse will be utilized weekly x4 and monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action implemented as needed for any deficient practice below the 95% threshold. Executive Director/designee is responsible to ensure compliance with employee records.DNS and Executive Director/Designee are responsible to ensure compliance with abuse policy.	

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	money and card had been replaced. Review of the facility's file related to Resident E's stolen card and money indicated the following: On 8/29/12, the resident became aware and reported the $20.00 gift card and three $1.00 bills missing from her purse in the chest of drawers in her room. An attached typed document, signed by the former Executive Director indicated the following: Resident E was interviewed related to the reported missing items, and the police were notified and investigated. Residents and staff on the resident's hall were interviewed related to misappropriation, and Social Services followed up with the resident. 3. Review of an Indiana State Department of Health Incident Report Form related to Residents H and M indicated on 9/17/12, a nurse (LPN #9) administering medications noticed the bubble pack medication packaging had been tampered with, and narcotic medications for Residents H and M had been replaced inside their bubble packs with different medications. A. The initial reporting documentation related to the medications was handwritten on plain paper and signed by LPN #9. The report indicated, "Monday,			

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	9/17/12 @ 4 PM, this writer was pulling meds [medications] - was getting [name of Resident H's] meds ready. I pulled her pain pill from the front card, then counted meds left, while pulling cards apart (they were rubberbanded) I noticed the 3rd card back the medication looking different [sic] in color. I turned card over & it had tape down the center....This writer then looked at narc [narcotic] sheets corresponding [with] the tampered meds I noticed on [Resident H's] sheet on 9/10/12 @ 9 pm count was 170 per this writer signing off. Following date (next dose) 9/11/12 @ 1 a.m. count was 152...." B. The same initial reporting documentation also indicated the narcotic bubble pack for Resident M's narcotics had been tampered with. The documentation indicated, "...Also on [Resident M's] sheet on same dates 9/10/12 @ 9 pm count was 169. Then next dose 9/11/12 @ 1 am count was 151." The file indicated LPN #7, LPN #5, and LPN #3 were suspended, the police were notified for investigation, and the nurses were subsequently terminated. Residents were monitored for negative effects of the events, and staff received inservice education.			

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	This federal tag is related to Complaint IN00117175. 3.1-28(a)			

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F0226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure implementation of its abuse prevention policy for preemployment screening for licensure and certification clear of findings for 4 of 9 employees whose files were reviewed for licensure and certification. (CNA #6, CNA #4, CNA #2, and LPN #7) The deficient practice affected 1 of 4 residents reviewed related to misappropriation in a sample of 21 residents. (Resident F) Findings include: 1. Review of the facility's policy for Abuse Prohibition, Reporting, and Investigation, provided by the Administrator on 10/10/12 at 7:20 a.m., indicated, "1. American Senior Communities will not permit residents to be subjected to abuse by anyone.... 2. Employment screening is done on all potential employees to assure that the facility does not employ individuals...b. Who do not have current licensure or certification clear of findings concerning....misappropriation of resident	F0226	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Resident F's money was replaced to his account, the employee involved with the alleged deficient practice was suspended pending investigation and ultimaately terminated. No other residents were affected by the alleged deficient practice **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.All potential employees requiring a certification/license will have proof/verification of their certification/license evidenced by a current copy of their certificate/license unless they are a c.n.a. awaiting testing. They then must provide proof of attendance in a c.n.a. class and will not be allowed to work with residents until this information is provided. Background checks will be completed for all potential	11/16/2012

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	property...." Employee files were reviewed on 10/11/12 at 9:55 a.m. A.. The file for CNA #6 indicated a hire date of 7/24/12. The filed lacked documentation of CNA #6's certification or Nurse Aide Training in preparation for certification testing. During interview on 10/11/12 at 3:45 p.m., the Director of Nursing Services (DNS) indicated the facility had realized recently not all employee files included appropriate screening of potential employees, including CNA certification. She indicated CNA #6 had not been checked for certification prior to employment. She indicated she had just phoned a Nurse Aide Trainer who told her CNA #6 "did have training, but did not show up for his certification test." B. The file for CNA #4 indicated a hire date of 7/30/12. Documentation in the file indicated CNA #4's certification was checked on 9/12/12. C. The file for CNA #2 indicated a hire date of 7/31/12. Documentation in the file indicated CNA #2's certification was checked on 9/12/12.		employees. No one will be allowed to work without an acceptable background check. SDC and Front office staff in-serviced 1:1 on necessary certification/licensure and background checks for employee records prior to being hired.All staff in-serviced on abuse by the SDC/designee-post test included. Non-compliance with these practices will result in suspension pending investigation and possible termination for any alleged abuse.SDC and Executive Director/designee are responsible to ensure compliance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All potential employees requiring a certification/license will have proof/verification of their certification/license evidenced by a current copy of their certificate/license unless they are a c.n.a. awaiting testing. They then must provide proof of attendance in a c.n.a. class and will not be allowed to work with residents until this information is provided. Background checks will be completed for all potential employees. No one will be allowed to work without an acceptable background check.SDC and Front office staff in-serviced 1:1 on necessary certification/licensure and background checks for employee	

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	D. The file for LPN #7 indicated a hire date of 7/31/12. Documentation in the filed indicated LPN #7's license was checked on 9/26/12. During interview on 10/15/12 at 3:45 p.m., Resident F indicated a facility staff member had taken and cashed checks from the checkbook he kept in a tub on the overbed table next to his bed. The resident indicated his name and his deceased mother's name were on his bank account, and the staff member had made the checks out to himself and signed the mother's name. Resident F indicated he reported the incident to the facility, and action was taken right away. The resident indicated the bank put stop payment on the checks, and his money had been returned to his account. Resident F indicated the staff member would be prosecuted. Review of the facility's file related to Resident F's stolen checks indicated the following: The resident became aware and reported the checks missing on 9/4/12 when the bank notified him his account was overdrawn. The checks appeared to be made out to a person whose name matched that of an employee at the facility. The employee was suspended pending investigation, and the police were notified and initiated an investigation.		records prior to being hired. All staff were in-serviced on abuse by the SDC/designee on (date) post test included. Non-compliance with these practices will result in suspension pending investigation and possible termination for any alleged abuse.SDC and Executive Director/designee are responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI audit tool for employee records will be utilized for all new hires.CQI tool for abuse will be utilized weekly x4, monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan implemented as needed for any deficient practices below the 95% threshold.Executive Director/designee is responsible to ensure compliance with employee records.DNS and Executive Director/designees are responsible to ensure compliance with abuse policy.	

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	The attached police report indicated evidence gathered by police included video footage of a former employee who worked as a CNA (CNA #6) at the facility. The video showed the former employee cashing three checks for the amounts missing from Resident F's bank account. An affidavit for the arrest of CNA #6 had been submitted to the local county Prosecutor's office. This federal tag is related to Complaint IN00117175 and Complaint IN00117302. 3.1-28(a)			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Based on record review and interview, the facility failed to ensure the resident with chest pain was assessed and care provided as ordered for 1 of 1 resident reviewed related to angina in a sample of 21. (Resident Q) B. Based on observation and record review, the facility failed to ensure the resident with a non-pressure wound received wound care to promote healing for 1 of 2 residents reviewed related to a non-pressure wound in a sample of 21. (Resident B) C. Based on observation, interview, and record review, the facility failed to ensure residents complaining of pain received assessment, care planning, and treatments to relieve the pain for 3 of 3 residents reviewed related to pain in a sample of 21. (Residents H, I, and O) Findings include: A. The clinical record for Resident Q was	F0309	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Resident Q did not have a negative outcome related to the alleged deficient practice and meds are documented given as prescribed.Resident B's wound to the right heel is resolved.Residents H is recieving pain medication as prescribed and as needed.Residents I is recieving pain medications as presribed and is effective. Resident O pain was assessed and a prn pain medication was ordered.**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practices.Licensed nurses in-serviced on assessing pain, change of condition, reporting, following MD orders and providing care by the SDC-post test included.All new orders are reviewed daily as well	11/16/2012

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	reviewed on 10/10/12 at 9:30 a.m. The record indicated the resident's diagnoses included, but were not limited to, angina pectoris. Physician's orders for September 2012 included, but were not limited to, "Nitrostat 0.4 mg sub [sublingual], Take 1 tablet sublingually every 5 mins [minutes] X3 doses as needed for chest pain. If no relief, call MD." The Care Plan, dated 5.25/11 with Giak date of 12/13/12, for "At risk for chest pains r/t [related to] Dx [diagnosis] of angina, CAD [coronary artery disease, hyperlipidemia and pericarditis" included, but was not limited to the following Approach, "Meds [medication] as ordered." A Progress Note for nursing, dated for 9/29/12 at 11:14 p.m., indicated, "Resident complained of pain in her chest, left arm, and left shoulder blade. She also complained of nausea. She was given nitro at 9:40 p.m. but pain was not relieved. Medical doctor was contact [sic] but was not reached. [Name of Nurse practitioner] was called and was told to send resident out. Resident was placed on 2 liters of O2 [oxygen] for comfort. Resident threw up once but nausea wasn't relieved."		as report sheets by the IDT/Unit Managers to determine if a change of condition and/or change in a residents comfort has occured. Findings from this review will be further reviewed i.e. - documentation, MD/family notification, pain assessments, orders obtained and plan of care updated.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses in-serviced on assessing pain, change of condition, reporting, following MD orders and providing care by the SDC on (date), post test included. All new orders are reviewed daily as well as report sheets by the IDT/Unit Managers to determine if a change of condition and/or change in a residents comfort has occured. Findings from this review will be further reviewed i.e. - documentation, MD/family notification, pain assessments, orders obtained and plan of care updated.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to**	

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	The Medication Administration Record failed to indicate Nitroglycerin was administered on 9/29/12. The Vital Signs Record indicated vital signs including temperature, pulse, respirations, blood pressure, and oxygen saturation were measured on 9/29/12 at 8:08 a.m. and at 11:13 p.m. but at no other times. The Resident Transfer Form, dated 9/29/12 at 11:08 p.m., indicated the resident was transferred to the hospital at 11:10 p.m. on 9/29/12. On 10/17/12 at 3:00 p.m., the Director of Nursing Services (DNS) was interviewed related to the administration of one instead of three Nitroglycerin and the resident's vital signs at the time the chest pain was reported. At this time, the DNS indicated the nurse had entered a revised Progress Note in the electronic documentation system, which included more information, and provided the following: A Progress Note for nursing, dated for 9/29/12 at 9:40 p.m., with a note in the electronic record indicating "Edited by [name of nurse] on 10/17/2012 at 12:31 p.m. Reason: Incorrect data," indicated,		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI audit for change of condition and pain assessment will be utilized weekly x4, monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will e implemented as needed for any deficient prctices below the 95% threshold. DNS/designee is responsible to ensure compliance	

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	"Resident complained of pain in her chest, left arm, and left shoulder blade. She also complained of nausea. She was given one nitro at 9:40 p.m. but pain was not relieved. Medical doctor was contact [sic] but was not reached. At that time [name of Nurse Practitioner] was called and told to give two baby aspirins and to send resident out the [name of local hospital]. Resident was placed on 2 liters of O2 [oxygen] for comfort. Resident threw up once afterwards nausea was relieved." When interviewed related to vital signs when the resident complained of chest pain and the physician's order for the two baby aspirins, the DNS did not respond. B. On 10/11/12 at 2:10 p.m., RN #21 was observed providing wound care for Resident B. The nurse removed a gauze wrap and dressing to the left heel. She cleansed the heel with normal saline, applied Bacitracin to the entire heel area, redressed the heel, and initialed and dated the dressing. While the heel was undressed, the heel area was observed as the nurse lifted the resident's foot/leg. No open areas were observed. On 10/16/12 at 4:40 p.m., Resident H was observed entering the dining room in his wheel chair. His right foot was in a boot			

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	apparatus. The clinical record for Resident B was reviewed on 10/15/12 at 12:50 p.m. A Non-pressure Wound Skin Evaluation Report, dated 10/10/12, indicated the resident had a diabetic ulcer to the right heel measuring 0.4 cm X 0.3 cm X 0.1 cm with a red wound color. Physician's orders for October 2012 included, but were not limited to, an order originally received 9/20/12, for "Bacitracin Zinc 500/gm oin [ointment], Cleanse right heel with normal saline pat dry apply Bacitracin cover with dry dressing twice daily and as needed for soilage or dislodgement." Orders related to wound care on the left heel were lacking. The Treatment Administration Record for October 2012 indicated RN #21's initials next to the 7-3 (day shift) entry for "Bacitracin Zinc 500/gm oin [ointment], Cleanse right heel with normal saline pat dry apply Bacitracin cover with dry dressing twice daily and as needed for soilage or dislodgement." C. 1. During Initial Tour on 10/10/12 at 4:00 a.m., Resident H's room was entered. The resident was observed in			

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	bed, and the lights were on. The resident was scooted toward the bottom of the bed, and the head of the bed was rolled up, so the resident's head was cocked up at the neck. The resident indicated she was "hurting like h--l" from the "top of her head to tip of her toes." She asked, "May I please have a pain pill," and she requested to be repositioned toward the top of the bed. The resident indicated she had been asking for a pain pill since 3:00 a.m. She indicated she should be able to get her pill an hour before to an hour after the scheduled dose. She indicated it was "always that way" that staff were not in a hurry to administer her pain medications. At this time, CNA #4 entered the room to assist the resident with repositioning. She indicated she was waiting for another aide to help with the care. LPN #19 entered Resident H's room to assist with repositioning. From the hallway, Resident H was heard asking, "Where's my pain pill?" LPN #19 sighed heavily, "Huh!" On 10/10/12 at 4:30, LPN #19 was interviewed in regard to Resident H's pain medication. He indicated, "We gotta be in compliance" related to administration of pain medications. He indicated Resident H received Percocet every four hours routinely, and "It's due at 5 o'clock." He indicated she also has a Fentanyl patch			

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	to help with pain management. He indicated, "She's adamant about her medications." The clinical record fro Resident H was reviewed on 10/15/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, chronic pain. The Nursing Quarterly Assessment, dated 9/17/12, indicated the resident reported she had had pain or hurting during the last five days, in her back and lower extremities, which was moderate, occasional, dull, aching, and throbbing, chronic, and decreased with medications and rest. The Care Plan, dated 7/16/12, indicated, "Potential for pain related to decrease mobility, back and leg pain, chronic pain, muscle spasms." Approaches included, but were not limited to, "Administer meds [medications] as ordered." Physician's orders for October 2012 included, but were not limited to, Baclofen twice daily and as needed for muscle spasms, Percocet for narcotic pain reliever every four hours routine, Fentanyl patch every 72 hours for narcotic pain relief, Neurontin three times daily for pain, and Tylenol 650 mg every six hours as needed for pain.			

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	The Medication Administration Record failed to indicate the Tylenol was administered when the resident complained of pain on 10/10/12. Resident Progress Notes for nursing included no entries related to pain assessment or management on 10/10/12. 2. On 10/15/12 at 10:55 a.m., Resident I was observed receiving incontinent care provided by CNA #14. The resident was lying on a low air loss mattress and had a dressing on the coccyx. The CNA rolled the soiled bed pad and four-layer draw sheet and the clean bed pad and four-layer draw sheet, and rolled the resident over the linens to replace soiled linen with clean. As she was rolled over the rolled linens, the resident indicated, "It hurts my butt [buttocks] to roll over that." The CNA started to place a wedge pillow for positioning, and the resident complained it hurt her back when the wedge was placed. During interview at this time, the resident indicated she does not hurt for awhile after she takes her pain pill. She indicated her pain medication is routine, and she doesn't think she gets pain medication in between routine doses. She indicated she is hurting before the next medication is due, and then she has to wait for it to relieve the pain.			

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The clinical record for Resident I was reviewed on 10/15/12 at 12:45 p.m.

The Care Plan, dated 4/25/12, indicated, "Resident has pain related to decreased mobility, Stage 4 pressure wound, history of C-diff [Clostridium difficile - organism causing diarrhea]." The Goal, with target date of 12/4/12, indicated, "Will have relief of pain within 30 to 60 minutes of intervention." Approaches included, but were not limited to, "Administer meds [medications] as ordered" and "Notify MD if pain is unrelieved or worsening."

Physician's orders for October 2012 included, but were not limited to, an order originally received 9/19/12 for, "Hydroco-Acetamin 10-325 mg tab [narcotic pain medication], take 1 tablet by mouth every four hours." No as needed pain medications were prescribed.

3. On 10/10/12 at 2:05 p.m., Resident O was observed in her wheel chair at the bedside. CNAs #20 and 22 prepared to transfer the resident to bed using the Hoyer lift. The resident was leaning to the left, and her left arm and hand were contracted up close to the body. Her feet and legs were on the foot pedals. As the Hoyer sling was connected to the lift, the resident indicated, "Don't hurt my

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	shoulder. You're hurting my shoulder. My feet hurt." As the Hoyer lifted the resident, she indicated, "You're hurting my leg. You're hurting my head." When interviewed as to whether the resident always complained of hurting during transfers, the CNAs nodded yes. On 10/16/12 at 1:20 p.m., CNAs #10 and #8 were observed transferring Resident O by Hoyer lift from wheel chair to bed. As the resident was lifted into bed, she complained of her feet hurting and "You're hurting my feet." CNA #10 pointed to the resident's feet and indicated she thought the resident had bunions that hurt her. As she provided care, CNA #10 indicated she thinks the resident's whole body must hurt. As the resident's stiff legs were separated for cleansing of the peri-area, she complained that her legs hurt. The resident complained of hurting as she was rolled from side to side. The clinical record for Resident O was reviewed on 10/11/12 at 10:00 a.m. The Care Plan, dated 11/25/11, indicated, "At risk for pain related to impaired mobility, history of CVA [cardiovascular accident] with left sided hemiparesis, osteoarthritis." Approaches included, but were not limited to, "Administer meds [medications] as ordered."			

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	155697	A. BUILDING 00 B. WING	10/17/2012

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	Physician's orders for October 2012 indicated the resident had no physician's order for pain medications. A pharmacy "Note to Attending Physician/Prescriber," dated 7/25/12, recommended discontinuation of the physician's order for Acetaminophen due to non-use during the preceding 150 days. The resident's physician signed in concurrence on 8/16/12. This federal tag is related to Complaint IN00117175 and Complaint IN00117302. 3.1-37(a)			

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F0314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview, and record review, the facility failed to ensure pressure wounds were assessed and care planned, treatments were in place, and manufacturer's instructions were followed for promotion of healing of pressure wounds for 3 of 5 residents reviewed related to pressure wounds in a sample of 21. (Residents I, K, and S) Findings include: 1. On 10/15/12 at 10:55 a.m., CNAs #12 and #14 were observed providing incontinent care for Resident I. Resident I was lying in bed on a specialty mattress with SenTech on the device attached to the mattress. During care a bed pad and draw sheet folded in four layers was observed under the resident's bottom. During interview at this time, CNA #14 indicated when the resident is having light bowel movements, one underpad and a	F0314	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Resident I now using only 1 flat regular draw sheet on the low air loss mattress bed per manufacturers instructions.Resident K's skin report, and care plan reflect the same pressure area, and dressing is in place as ordered. The c.n.a.'s report to the nurse immediately if the dressing has come off. Resident S has passed away **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.Licensed nurses in-serviced on asssessing residents skin upon admission and weekly by the wound nurse/designee. In-service also	11/16/2012

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	drawsheet are used under the resident, but when the resident has large or loose bowel movements, two underpads and the draw sheet are used. The clinical record for Resident I was reviewed on 10/15/12 at 12:45 p.m. The record indicated the resident was admitted 3/12/12 with a Stage 4 pressure wound to the coccyx. The Care Plan, with start date of 7/16/12, indicated, "Skin: Resident has impaired skin integrity: Pressure Wound; Location: Coccyx." Approaches included, but were not limited to, "Low air loss mattress." The Pressure Wound Skin Evaluation Report, dated 10/15/12, indicated the resident's wound was Stage 4, 6.1 X 8.6 X 1.0 cm with undermining in two areas. Manufacturer's instructions from the company providing the Sentech Stage IV 2000/3000 low air loss mattress for Resident I were provided by the Medical Records Director on 10/17/12 at 2:15 p.m. The instructions indicated, "In order to reduce the physical factors that cause pressure ulcers...recommends the appropriate use of bed linens with all of its products." Specifically indicated for the SenTech Stage IV 2000/3000 were		given on the use of specialty mattresses per manufacturer instructions-post test included. All new admissions and re-admissions will have their skin assessed by the admitting charge nurse/unit manager for any alterations in skin integrity. Weekly skin assessments will be completed by the charge nurse for all residents as scheduled.Any wounds identified on admission or on the weekly skin assessment will be measured, MD notified, treatment obtained, indivdual wound sheet completed and care planned by charge nurse/unit manager. The wound nurse will then assess findings to ensure treatment in place and appropriate documentation completed. Non-compliance with these practices will result in further education including disciplinary action.Wound nurse/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Licensed nurses were in-serviced on asssessing residents skin upon admission and weekly on (date) by the wound nurse/designee. Inservice also given on the use of specialty mattresses per manufacturer instructions. Post test included. All new admissions and re-admissions will have their skin assessed by the admitting charge	

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	three bulleted items: "One flat regular turn sheet; One disposable chux...." 2. On 10/10/12 at 2:50 p.m., LPN #11 was observed completing wound care for Resident K. During interview as the nurse prepared to provide care, she indicated the coccyx wound dressing is changed every three days. She indicated she would cleanse the wound with normal saline, pat dry, and apply DuoDerm. The resident was rolled to her left side and the area was exposed. The wound was observed to have no dressing, and the nurse indicated it probably came off during pericare. When interviewed related to the aide's having notified her the dressing had come off and needed to be replaced, the nurse indicated, "[Name of CNA #24] didn't mention it." The clinical record for Resident K was reviewed on 10/15/12 at 1:55 p.m. The Care Plan, dated 7/19/12, indicated, "Resident has impaired skin integrity: stage 2 pressure wound coccyx." Approaches included, but were not limited to, "Treatment as ordered." A physician's order, received 10/4/12, indicated, "Cleanse area to coccyx [symbol for with] NS [normal saline], pat dry & apply duoderm to O/A [open area]		nurse/unit manager for any alterations in skin integrity. Weekly skin assessments will be completed by the charge nurse on all residents as scheduled.Any wounds identified on admission or on the weekly skin assessment will be measured, MD notified, treatment obtained, indivdual wound sheet completed and care planned by charge nurse/unit manager. The wound nurse will then assess findings to ensure treatment in place and appropriate documentation completed. DNS/designee will make rounds on all 3 shifts to ensure specialty mattress are being used per manufacturer instructions. Non-compliance with these practices will result in further education including disciplinary action.The wound nurse and DNS/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CQI audit tool for skin management will be utilized weekly x 4, monthly x 6 and quaterly thereafter.CQI audit tool for specialty beds will be utilized weekly x4, monthly x6 and quarterly thereafter during all 3 shifts.Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices below the 95%	

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	q [every] 3 days & prn [as needed] soilage/dislodgement." The Pressure Wound Skin Evaluation Report, dated 10/15/12, indicated the resident's wound was to the right buttock, Stage 2, originally noted on 8/22/12, with granulation tissue, 3.3 X 2.0 x 0.1 cm, and without odor or drainage. 3. The clinical record for Resident S was reviewed on 10/17/12 at 9:20 a.m. The record indicated the resident was readmitted from the hospital on 10/5/12. The Nursing Admission Assessment, dated 10/5/12, indicated with a check mark in the assessment section for Skin Conditions - Wound: pressure sore - coccyx. An instructional notation on the assessment indicated, "If areas of skin integrity alteration (wound and non-wound) are noted on admission measure each area and complete a skin sheet for each area." "Notes" on the assessment indicated, "...Dressing on coccyx clean, dry, and intact...." A physician's order, dated 10/6/12, included, but was not limited to, "Cleanse coccyx q [every] other day [symbol for with] NS [normal saline], pat dry, cover [symbol for with] Allevyn for reddened area."		threshold.Wound nurse and DNS/designee is responsible to ensure compliance.	

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A Resident Progress Note for nursing, dated 10/7/12 at 1:56 p.m., indicated, "...Pressure area noted to coccyx and tx [treatment] cont [continues] as ordered." Other documentation related to the wound was not in Resident Progress Notes from admission through 10/11/12.

The Treatment Administration Record indicated the treatment was started on 10/8/12 with a nurse's initials next to the entry for "Cleanse coccyx q [every] other day [symbol for with] NS [normal saline], pat dry, cover [symbol for with] Allevyn for reddened area."

The Weekly Nursing Summary and Skin Assessment, dated 10/9/12, indicated, for Skin Assessment: warm and dry, pink, and "none of the above" related to skin issues.

A physician's order for a hospice consult was received on 10/11/12.

The hospice Nursing Comprehensive Admission Assessment, dated 10/11/12, indicated the resident had an unstageable pressure ulcer to the left upper buttock measuring length X width X depth of 2.0 X 2.0 X U (unknown or unstageable) cm. Further description of the wound was not indicated on the hospice record.

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	On 10/12/12, physician's orders were received for "Cleanse upper buttock [symbol for with] soap & water, pat dry, apply Santyl & dry dressing qd [every day], [symbol for change] PRN [as needed] St. [Stage] 4." During interview on 10/17/12 at 5:40 p.m., the Director of Nursing Services (DNS) indicated the coccyx wound was not assessed, including measurements, from admission on 10/5/12 through the time of the resident's admission to hospice on 10/11/12, when the hospice nurse assessed and measured the wound. This federal tag is related to Complaint IN00117175. 3.1-40(a)(2)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure a resident was assessed related to the need for medication before administration for 1 of 1 resident reviewed for use of Roxanol and Ativan Intensol for care of the dying resident from a sample of 21 residents. (Resident P) Findings include: The clinical record for Resident P was reviewed on 10/10/12 at 10:15 a.m. The	F0329	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident P passed away**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.Chart audit was completed by DNS/designee to ensure residents on pain medication are	11/16/2012

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	record indicated the resident was admitted to the facility on 8/20/12 and was receiving hospice services at the time of admission. A hospice nurse's note for 9/27/12 at 12:30 (a.m. or p.m. not indicated) indicated, "[Name of hospice] RN here for visit R/T [related to] report of patient decline. Routine assessment completed. Patient having labored respirations at 28 X [times] min [minute]. Shallow - reports pain but unable to verbalize # on pain scale. Patient appears to be starting dying phase. Dtr [daughter] at bedside. Requesting comfort for patient. [Name of hospice] notified and N.O.'s [new orders] received. Please call if meds [medications] not effective. Thanks. Physician's orders received 9/27/12 at 12:30 p.m., indicated, "[arrow pointing up - increase] Roxanol [narcotic pain medication] 20 mg/1 ml to 15 mg/0.75 ml q [every] hr [hour] PRN [as needed] SOA [shortness of air] Pain/restlessness SL [sublingual]/PO [by mouth]. [Symbol for change] Ativan PO to Ativan Intensol [antianxiety medication] 2 mg/1 ml give 1 mg/0.5 ml q 1 hr SL/PO PRN for SOA/anxiety." Resident Progress Notes for nursing, dated 9/29/12, at 4:25 p.m., indicated,		assessed for pain with documentation on the back of the MAR for effectiveness.Licensed nurses in-serviced on caring for the dying resident and assessing residents for pain and documenting on the back of the MAR including effectiveness by the SDC/designee-post test included. Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**Dying residents will be monitored each shift by DNS/designee to ensure pain assessments completed and pain medication given as ordered.Licensed nurses were in-serviced on caring for the dying resident and assessing residents for pain and documenting on the back of the MAR including effectiveness by the SDC/designee on (date), post test included. Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI audit for pain assessment will be completed	

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	"Rested abed most of day. PRN morphine and ativan given thruout [sic] the day. HOB [head of bed] elevated to assist with moving air. O2 [oxygen] on per n/c [nasal cannula]. Has period of restlessness. Frequently takes O2 off. Encouraged to leave O2 on. Is presently resting with eyes closed. The Vital Signs record for 9/29/12 indicated the resident's respirations at 8:11 a.m. were 21 per minute. Vital Signs on 9/29/12 at 4:22 p.m., indicated, blood pressure of 124/66, respirations 20 per minute, pulse 64 per minute, and temperature 97.7 degrees Fahrenheit. No other vital signs were indicated for 9/29/12. The next Resident Progress Note for nursing was a late entry on 9/30/12 at 11:52 a.m. for 9/29/12 at 11:36 p.m., and indicated, "Resident was able to open her eyes when her name was called at 9:00 p.m. Routine pain medication and ativan was given on every hour to reduce pain and anxiety. At 9:30 p.m., resident was given morphine 0.75 ml. and ativan 0.50 ml. Her pulse was 56 bpm [beats per minute] and her O2 sat [saturation] was 94%. At 10:00 p.m., when entering the room, noticed that resident had expired. A second nurse verified resident's death. The doctor and NP [nurse practitioner]		weekly x4, monthly x 6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practice below the 95% threshold.DNS/designee is responsible to ensure compliance.	

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	was called and [name of hospice] was called. Family was called directly afterwards. They requested to come in and view the body. Awaiting the arrival of the family." During interview on 10/10/12 at 1:50 p.m., the Medical Records Director indicated no other assessments or vital signs were available for 9/29/12. The narcotic record for Roxanol indicated the medication was dispensed as follows on 9/29/12: 3:00 a.m., 6:00 a.m., 8:00 a.m., 9:00 a.m., 2:00 p.m., 3:15 p.m., 4:30 p.m., 5:35 p.m., 6:30 p.m., 8:30 p.m., and 9:30 p.m. The narcotic record for Ativan Intensol indicated the medication was dispensed as follows on 9/29/12: 3:00 a.m., 8:00 a.m., 9:00 a.m., 11:00 a.m., 1:00 p.m., 3:20 p.m., 4:30 p.m., 5:35 p.m., 6:30 p.m., 8:30 p.m., and 9:30 p.m. The Medication Administration Record for 9/29/12 indicated four doses of the Roxanol and four doses of the Ativan Intensol were administered on 9/29/12. Documentation on the reverse was lacking related to the Reason the as needed medications were administered and the Results/Response to the medication.			

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	The Care Plan, dated 8/21/12, indicated, "Resident requires hospice R/T [related to] end stage COPD [chronic obstructive pulmonary disease]." Approaches included, but were not limited to, "Administer pain medication as ordered.....Assess for sign of pain, both verbal and non-verbal; treat as indicated. be available for resident/family...provide comfort and support. Notify Hospice as needed...." During interview on 10/11/12 at 3:20 p.m., the Director of Nursing Services indicated the resident "fluctuated with the pain," and she would not expect a nurse to assess the resident in regard to administration of the medications, since the resident was a hospice patient and in pain. This federal tag is related to Complaint IN00117302. 3.1-48(a)(3) 3.1-48(a)(4)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure pharmacy provided medications for administration as ordered for 3 of 5 residents reviewed related to narcotic medication availability in a sample of 21. (Residents C, D, and H) Findings include: 1. During interview on 10/15/12 at 9:50 a.m., Resident D indicated she receives a routine pain medication every morning, and she can ask the nurse for more pain medication during the day. Resident D	F0425	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Resident D is recieving her pain medication as prescribed and has a narcotic sheet in place.Resident H's pain medication is available and given as prescribed.Resident C's fentanyl patch has since been dc'd and pain assessment completed prior to dc'ing med. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All resident	11/16/2012

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	indicated her right knee hurts her. She indicated pharmacy doesn't always send the medication timely. She indicated she asks, and the nurse tells her "pharmacy hasn't sent it yet." The clinical record for Resident D was reviewed on 10/15/12 at 4:05 p.m. Physician's orders for September 2012 included, but were not limited to, an order originally received 8/14/11, for "Hydroco/Acetamin 5-500 mg tab [narcotic pain medication], take 1 tablet by mouth once daily at 9:00 a.m. for chronic leg pain" and "Hydroco/Acetamin 5-500 mg tab, take 1 tablet by mouth every 4 hours as needed for pain." The Medication Administration Record (MAR) for September 2012 indicated the resident received the routine dose of narcotic pain medication daily in September 2012, except on 9/24/12 and 9/25/12. On these dates, the initials of the nurse who was to administer the medication were circled to indicate the medication was not administered. No explanation of the omission was written on the reverse side of the MAR. The reverse side of the MAR indicated with initials that LPN #5 obtained the medication from the Pixus emergency drug supply on 9/26/12, but the initials on		MAR's/TAR's audited to ensure all physician orders/medications are listed correctly and that all medications are available.All residents have the potential to be affected by the alleged deficient practice.Licensed nurses in-serviced on adminsitering/re-ordering medications timely and EDK protocols by the SDC/designee on (date), post test included. MAR's/TAR's are monitored weekly by the management nurses to ensure availabilty of medications and narcotic sheets present and utilized.DNA/designee will review monthly pharmacy narcotic usage report to monitor EDK narcotic usage.Non-compliance with these practices will result in further education including disciplinary action.DNS and wound nurse/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**All resident MAR's/TAR's audited to ensure all physician orders/medications are listed correctly and that all medications are available. Licensed nurses-in-serviced on adminsitering/re-ordering medications timely and EDK protocols by the SDC/designee-post test included. MAR's/TAR's are monitored weekly by the	

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	the record of administration on that date indicated the medication was administered by LPN #15. Resident Progress Notes for 9/24 and 9/25/12 lacked documentation related to the medication not being administered. The Narcotic Count Record for Resident D lacked documentation of the Hydrocodone/Acetaminophen for the dates of 9/24 through 9/27/12, although the medication was documented as administered on those dates, except for 9/24 and 9/25/12. During interview on 10/17/12 at 3:00 p.m., the Director of Nursing Services (DNS) indicated she had researched, and there was no record to explain why the medication was not administered on 9/24 and 9/25/12. She indicated a Narcotic Count Record was not available for the dates of 9/24 through 9/27/12, but she did not know why. 2. The clinical record for Resident H was reviewed on 10/15/12 at 1:30 p.m. Physician's orders for September 2012 included, but were not limited to, an order originally received 7/29/12, for "Oxycodone/Acetaminophen 10-325 tab, take 1 tablet by mouth every 4 hours -		management nurses to ensure availabilty of medications and narcotic sheets present and utilized. Non-compliance with these practices will result in further education including disciplinary action.DNS/designee will review monthly pharmacy narcotic usage report to monitor EDK narcotic usage.DNS and wound nurse/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI pharmacy services tool will be utilized weekly x 4, monthly x 6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will be implemented for any deficient practices below the 95% thereshold DNS/designee is responsible to ensure compliance.	

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	increased pain." The MAR for September 2012 indicated circles around the nurse's initials for the following scheduled doses of the Oxycodone/Acetaminophen: 9/8/12 at 9:00 p.m., and 9/9/12 at 1:00 a.m. and 5:00 a.m. The reverse side of the MAR indicated, "9/8/12 9P [9:00 p.m.] Percocet 10/325 [symbol for not] avail [available] EDK [emergency drug kit] depleted, MD aware, to send Rx [prescription]. 9/9/12 1A [1:00 a.m.] [ditto marks under Percocet 10/325] Awaiting Rx. 9/9/12 4A [4:00 a.m.] Tylenol 650 mg pain." 3. The clinical record for Resident C was reviewed on 10/15/12 at 1:15 p.m. Physician's orders for September 2012 included, but were not limited to, an order originally received 8/4/12 for "Fentanyl 50mcg/hr [narcotic pain medication administered transdermally], apply 1 patch topically every 72 hours." The MAR for September 2012 indicated the nurses' initials were circled next to the entry for Fentanyl patches scheduled on the following dates: 9/14, 9/17, 9/20, and 9/23/12. The reverse side of the MAR indicated the following related to the Fentanyl patch: "9/17 Patch [symbol for not] available - pharm [pharmacy]			

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	notified. 9/20/12 MD aware of need for new script." Resident Progress Notes for 9/14 through 9/23/12 lacked documentation related to the unavailable medication. During interview on 10/17/12 at 3:00 p.m., the DNS indicated the Narcotic Count Record showed the Fentanyl was administered on 9/14/12 but not on the other dates. The DNS was uncertain why the nurse's initials on 9/14/12 appeared to be circled. This federal tag is related to Complaint IN00117175. 3.1-25(a)			

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review and interview, the facility failed to ensure pharmacy established an accurate process for tracking and reconciling narcotic	F0431	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**Resident J is recieving	11/16/2012

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	medications. The deficient practice affected 1 of 5 residents reviewed related to narcotic medication administration in a sample of 21. (Residents J) Findings include: The clinical record for Resident J was reviewed on 10/15/12 at 5:00 p.m. Physician's orders for September 2012 included, but were not limited to, an order originally dated 3/23/12, for "Hydroco/Acetamin 500 mg tab [narcotic pain medication], take 1 tablet by mouth once daily routinely" and "Hydroco/Acetamin 500 mg tab, take 1 tablet by mouth every 6 hours as needed for moderate pain...." The Medication Administration Record for September 2012 indicated the narcotic pain medication was administered at 9:00 a.m. daily on September 1 through September 30, 2012. The reverse side of the MAR indicated the 9:00 a.m. dose was obtained from the Emergency Drug Kit on 9/4/12. The MAR for September 2012 indicated the narcotic pain medication was administered 8 times on an as-needed basis.		pain medication as prescribed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.All residents MAR's/TAR's audited to ensure all physician orders/medications are listed correctly and that all medications are available.All resident narcotic sheets and on-site medications audited to ensure documentation reflects correct amount of medication has been dispensed.Licensed nurse's in-serviced on documenting narcotic pain medications on the correct narcotic count sheet and administering narcotic pain medications as prescribed.MAR's and TAR's are reviewed weekly by the managment nurses to ensure medications are given as prescribed and narcotic count sheets are utilized appropriately for routine/non-routine medications. Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**All residents MAR's/TAR's audited to ensure all physician	

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	Two separate Narcotic Count Sheets were maintained - one for the routine medication at 9:00 a.m. and one for the as-needed medication. The Narcotic Count Sheet for routine doses, with dates from 8/11/12 through 9/1/12, indicated the sheet was used for non-routine doses 9 times. The Narcotic Count Sheet for as-needed doses, with dates from 9/11/12 through 10/18/12, indicated the sheet was used for the routine 9:00 a.m. doses on all dates from 9/11 through 9/30/12. No Narcotic Count Sheet indicated the narcotic medication was administered on 9/4 through 9/10/12. During interview on 10/17/12 at 3:00 p.m., the Director of Nursing Services provided documentation a dose of the medication was obtained from the emergency drug supply on 9/10/12, when the MAR indicated the routine dose was administered at 9:00 a.m. and an as-needed dose at 5:00 p.m. She indicated she could not account for where the medication came from for the routine medication doses on 9/5, 9/6, 9/7, 9/8, and 9/9/12. She indicated the pharmacy's policies related to narcotic medications changed at the first of September and there had been a problem with communication with pharmacy. This federal tag is related to Complaint		orders/medications are listed correctly and that all medications are available.All resident narcotic sheets and on-site medications audited to ensure documentation reflects correct amount of medication has been dispensed. Licensed nurse's in-serviced on documenting narcotic pain medications on the correct narcotic count sheet and administering narcotic pain medications as prescribed.MAR's and TAR's are reviewed weekly by the managment nurses to ensure medications are given as prescribed and narcotic count sheets are utilized appropriately for routine/non-routine medications. Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI audit for pharmacy services will be utilized weekly x4, monthly x 6 and quarterly thereater.Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practice below the 95% threshold.DNS/designee is responsible to ensure compliance	

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	IN00117175. 3.1-25(n)			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure	F0441	**What corrective action(s) will be accomplished for those**	11/16/2012

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	infection control policies were followed related to employee screening for tuberculosis, handwashing/glove use, and isolation precautions. The deficient practice related to tuberculosis affected 4 of 9 employees whose files were reviewed related to screening for tuberculosis. The deficient practice related to handwashing/isolation precautions affected 1 of 1 resident reviewed related to isolation for Clostridium difficile infection in a sample of 21. Findings include: 1. The facility's policy related to "Employee Screening - Tuberculosis (TB)" was provided by the Nurse Consultant on 10/15/12 at 1:00 p.m. The policy indicated, "All employees will be screened for TB in accordance with state and federal regulations." The policy indicated newly hired employees would be tested using the two-step testing procedure, requiring an initial skin test followed by a second skin test 1 to 3 weeks later, unless the employee had a documented negative TB test within the preceding 12 months. Employee files were reviewed on 10/11/12 at 9:55 a.m. A. The file for CNA #6 indicated a hire		**residents found to have been affected by the deficient practice?**No residents were affected by the alleged deficient practice related to TB screening.Resident I is no longer in contact isolation Employee 6,2,5,and 21 have completed TB skin test **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?**All residents have the potential to be affected by the alleged deficient practice.Audit completed on all employee records to ensure all employees have completed TB skin tests.SDC in-serviced 1:1 on proper TB skin test protocols for new hires.Nursing staff in-serviced on infection control practices for residents in isolation, hand washing and glove use by the SDC/designee-post test included.Skills validations for hand washing/glove use/proper isolation procedures will be completed on or before (date) by the SDC/designee.Audit completed on c.n.a. assignment sheets to ensure they include type of isolation for any resident in isolation to ensure c.n.a.'s are aware for care of the resident.Audit completed to ensure all residents in isolation have their rooms properly identified to be in isolation along with having the proper isolation precaution supplies stationed	

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	date of 7/24/12. The file lacked documentation of CNA #6's second step TB skin test. B. The file for CNA #2 indicated a hire date of 7/31/12. The file lacked documentation of CNA #2's second step TB skin test. C. The file for LPN #5 indicated a hire date of 8/5/11. The file lacked documentation of LPN #5's second step TB skin test. D. The file for RN #21 indicated a hire date of 6/6/12. The file lacked documentation of RN #21's second step TB skin test. During the Daily Conference on 10/11/12 at 4:15 p.m., the Administrator indicated the facility had no other records of TB skin tests. 2. During Initial Tour on 10/10/12 at 4:00 a.m., LPN # 19 indicated he would need to check to be sure but thought Resident I was on isolation precautions related to VRE (Vancomycin Resistant Enterococcus) in the urine. During interview on 10/10/12 at 7:20 a.m., RN #17 indicated Resident I's isolation was related to VRE of the urine,		outside each isolation room.Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**Audit completed on all employee records to ensure all employees have completed TB skin tests. SDC in-serviced 1:1 on proper TB skin test protocols for new hires.ED will monitor all new hires to ensure all new employees have been given TB test prior to hire and 2nd step within 21 days of hire.Nursing staff in-serviced on infection control practices for esidents in isolation, hand washing and glove use by the SDC/designee-post test included.Skills validations for hand washing/glove use/proper isolation procedures will be completed on or before (date) by the SDC/designee.Audit completed on c.n.a. assignment sheets to ensure they include type of isolation for any resident in isolation to ensure c.n.a.'s are aware for care of the resident.Audit completed to ensure all residents in isolation have their rooms properly identified to be in isolation along with having the proper isolation precaution supplies stationed outside each isolation	

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	and the urine was contained because the resident had a Foley catheter. During interview on 10/15/12 at 10:40 a.m. at the bedside of Resident I, CNA #14 indicated she was preparing to check to see if Resident I had a bowel movement and needed care. On 10/15/12 at 10:55 a.m., CNAs #12 and #14 were observed providing incontinent care for Resident I. Both CNAs were wearing gloves, and neither CNA was wearing an isolation gown to cover her uniform. Resident I had been incontinent of stool and was cleansed and changed by CNA #14. During care, CNA #12 left the bedside to attend to another resident. CNA #14 completed the incontinent care, and without changing gloves or washing her hands, proceeded to assist the resident into a clean gown, replace the bed covers, manipulate the call light and TV remote, and arrange the overbed table. CNA #14 then washed her hands and left the room to get the nurse. Shortly afterwards, RN #17 and CNA #14 entered the room wearing gloves and isolation gowns. During interview at this time, RN #17 indicated the resident was on isolation for C-diff (Clostridium difficile - bacteria causing diarrhea). CNA #14 indicated she had not worn an isolation gown during incontinent care		room. Non-compliance with these practices will result in further education including disciplinary action.DNS/designee is responsible to ensure compliance.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**CQI audit tool for infection control will be utilized weekly x4, monthly x6 and quarterly thereafter.CQI TB audit tool for employee records will be utilized weekly x4, monthly x6 and quarterly thereafter.Findings from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practice below the 95% threshold. DNS and Executive Director/designee are responsible to ensure compliance.	

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because she "didn't know about the C-diff - it's new to me."

The clinical record for Resident I was reviewed on 10/15/12 at 12:45 p.m.

A physician's order, dated 10/6/12, included, but was not limited to, "Flagyl...X 14 days r/t [related to] C-diff - repeat stool C [culture] X 2 [two times] [symbol for after] Flagyl." The Care Plan Update section of the physician's order included in Intervention related to C-diff, "Contact isolation."

The facility's policy for "Infection Control and Prevention" was provided by the Nurse Consultant on 10/15/12 at 1:00 p.m. The policy indicated in the section on "Standard Precautions," "...Gloves...Change gloves during care if hands will move from a contaminated site to a clean site." The "Contact Precautions," section indicated, "...Use of Personal Protective Equipment - Gown: ...Put on a gown upon entry to room....Gown protects clothing from potential contamination from direct contact with resident, environmental surfaces or equipment...."

The facility's "Handwashing Policy and Procedure" was provided by the Nurse Consultant on 10/15/12 at 1:00 p.m. The

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	policy indicated, "Purpose: 1. To prevent the spread of infectious disease....Procedure: ...5. Decontaminate hands if moving from a contaminated body site to a clean body site during patient care...." This federal tag is related to Complaint IN00117175. 3.1-14(t)(1) 3.1-18(a)(2) 3.1-18(l)			

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F0465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and record review, the facility failed to ensure a sanitary and comfortable environment by keeping radiators free of dust, cobwebs, and debris, by repairing leaks/replacing stained ceiling tiles, and by keeping the kitchen floors clean, sink faucet repaired, and shelves rust-free. The deficient practice affected 12 of 12 residents whose radiators were observed, residents using the 60 and 20 halls where the ceiling tiles were stained, and residents served from the facility's kitchen. Findings include: 1. On 10/11/12 at 9:20 a.m., the Administrator provided a list labeled PTAC (Packaged Terminal Air Conditioner) Cleanout List. The Administrator indicated the Maintenance Director was working on the radiator units in the facility. The Administrator indicated blanks next to room numbers indicated the radiators not yet "complete" for cleanout. Review of the list indicated the units were "complete" in the following rooms: Room 20, Room 22, Room 25, and Room 29.	F0465	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The radiators of 12 residents (Rm 7(2 residents), Rm 50(1 resident), Rm 22(2 residents), Rm 29(2 residents), Rm 25(2 residents), Rm 60(2 residents), and Rm 20(1 resident), have been cleaned, serviced and filters installed.The stained ceiling tiles on halls 60 and 20 have been replaced.The fan/vent in the dishroom has been cleaned, shelves purchased to replace those rusted. Leaking faucet has been repaired. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice.All facility radiators inspected/serviced/cleaned and filters placed.All facility halls inspected and stained ceiling tiles replaced.Kitchen and dishroom area inspected, all fans/vents cleaned. All shelving inspected for rust. Customer Care Rep rounds continued by Department Managers to not only communicate with residents, but	11/16/2012

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	During an environmental tour with the Maintenance Director on 10/11/12 between 11:00 a.m. and 11:50 a.m., the following was observed: A. In Room 7 (two residents), the front of the radiator was removed by the Maintenance Director. The filter on the unit was clean. In the floor of the radiator were a toy football, toy car, small doll toy, and a wound measuring device, all laden with dust. The interior of the unit was heavily laden with thick gray dusty spider webs. During interview at this time, the Maintenance Director indicated the radiator was "in bad shape." B. In Room 50 (one resident), the front of the radiator was removed by the Maintenance Director. The unit had no filter in place. Within the unit were plastic bags, and dust, debris, and spider webs were throughout the interior. C. In Room 22 (two residents), the front of the radiator was removed by the Maintenance Director. The unit had no filter in place. The inside of the cover was dusty and webbed. Black areas were observed, which the Maintenance Director indicated might be concentrated dust and dirt.		to also identify areas for Maintenance to address.All staff inserviced on identifying/communicating environmental concerns. A new Maintenance request form was implemented to communicate concerns to the appropriate staff. Residents were presented with the new Maintenance request form in residesnt council.Maintenance Director, Housekeeping Supervisor and Dietary Manager in-serviced 1:1 on preventative maintenance program and providing a sanitary comfortable environment. Non-compliance with preventative maintenance program will result in further education including disciplinary action.Maintenance/designee is responsible to ensure compliance with preventative maintenance program.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** New Maintenance request form implemented to communicate maintenance needs. Both staff and residents informed of new communication tool.Maintenance Director, Housekeeping/Laundry Supervisor and Dietary Manager in-serviced 1:1 on preventative maintenance and providing a sanitary comfortable environment.Non compliance will result in further education	

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	D. In Room 29 (two residents), the front cover of the radiator was removed by the Maintenance Director. The unit's filter had a light coating of dust. The Maintenance Director indicated he checks filters once a month. Thick dust was on the interior cover, and paper debris was in the unit's fan blades. E. In Room 25 (two residents), the front cover of the radiator was removed by the Maintenance Director. The filter was soiled with dust. Thick dust was on the back of the cover. A dryer sheet and candy wrapper were inside the unit, along with thick dust and webs. Tissues were in the unit's fan blades. F. In Room 60 (two residents), the front of the radiator was removed by the Maintenance Director. The filter was covered with thick dust. Paper, tissues, and a candy wrapper were in the unit's fan blades. G. In Room 20 (one resident), the Maintenance Director removed the front cover of the radiator. The unit had no filter. A light coating of dust was on the inside of the front cover. Dust was on the floor of the unit. 2. During the Environmental Tour on 10/11/12 from 11:00 a.m. to 11:50 a.m.		including disciplinary action.Maintenance/designee is responsible to follow preventative maintenance program**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Customer Care Rep Rounds to be done daily M-F, ongoing.CQI audit tool for a sanitary and comfortable environment will be utilized weekly x4, monthly x6 and quarterly thereafter.Executive Director/designee is resposible to ensure compliance.	

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	with the Maintenance Director, the following was observed: A. The ceiling tile in the hallway outside Room 60 was stained with brown, circular water marks. During interview at this time, the Maintenance Director indicated the sprinkler system had leaked in that spot, and had now been repaired. B. The ceiling tile in the hallway outside Room 31 was stained with brown, circular water marks. The Maintenance Director indicated he had located a leak on the roof, had put tar on it for repair but is "still working on it." The Assistant Director of Nursing was interviewed at this time and indicated it had been a "long time" since the facility had to use blankets on the floor to catch water in that area. 3. The following was observed in the dishroom of the facility's kitchen on 10/11/12 at 3:50 p.m.: dishroom: A. The overhead fan/vent was covered with a fuzzy-looking black substance. During interview at this time, the Dietary Manager indicated the Maintenance Director cleans the fan/vent. B. The wide shelves holding the plastic dish racks were rusted through along the edges.			

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	C. The faucet of the rinse sink was leaking, and water was running down the wall and out into the floor drain. The Dietary Manager indicated a part for the faucet was on order. This federal tag is related to Complaint IN00117175 and Complaint IN00117302. 3.1-19(f)			

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F0518 SS=F	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. Based on interview and record review, the facility failed to ensure staff followed emergency plans related to fire for 1 of 1 potential fire emergency. The deficient practice had the potential to affect 70 of 70 residents residing in the facility. Findings include: During interview on 10/10/12 at 9:35 a.m., the Maintenance Director indicated recently the Fire Department had been called to the building. The Maintenance Director indicated he had heard everything from "flames shooting out" to "smoke billowing" was seen in Room 10. The Maintenance Director indicated the wiring in the radiator was faulty and overheated and possibly created a puff of smoke. During interview on 10/11/12 at 8:30 a.m., the Director of Nursing Services (DNS) indicated LPN #9 called her at home one evening to ask the DNS whether to call the Fire Department when smoke was coming from the radiator in	F0518	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the alleged deficient practice.All staff in-serviced by SDC/designee on the emergency procedure for potential fire emergency-post test includedFire drills conducted by Maintenance/designee on all 3 shifts to ensure emergency fire procedure is being followed.Non-compliance with these practices will result in further education including disciplinary action.Maintenance Director/dsesignee is responsible to ensure compliance.**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All staff in-serviced by	11/16/2012

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	Room 10. The DNS indicated she told LPN #9 to call, since it was better to be safe than sorry. During interview on 10/17/12 at 4:05 p.m., LPN #9 indicated on the evening of the Fire Department visit, she was just coming in from her break, and staff called her to Room 10, because there were sparks from the radiator. LPN #9 indicated she went into the room, and the nurse and aides were getting one of the residents out of the room. LPN #9 indicated the other resident for Room 10 was just returning from the dining room and did not enter the room. LPN #9 indicated she phoned the Maintenance Director, then the Fire Department, and then the DNS. LPN #9 indicated she called the supervisors, because she wanted to be sure calling the Fire Department was the right thing to do. The facility policy for General Fire Action Plan was provided by the Administrator from the facility's Emergency Binder. The plan indicated, "In case of fire - follow RACE procedure: ...Alarm: Pull alarm - located at fire exits.... The Fire Department's run report was provided on the conference room table on 10/15/12 at 3:15 p.m. Review of the		SDC/designee on the emergency procedure for potential fire emergency-post test included.Fire drills conducted by Maintenance/designee on all 3 shifts to ensure emergency fire procedure is being followed. Non-compliance with these practices will result in further education including disciplinary action.**How the corrective action(s) will be maintained to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CQI Audit tool for emergency fire drill protocol will be completed x4 monthly, then quarterly.Findings for CQI audit will be processed monthly and an action plan will be implemented for any deficient practices below the 95% threshold.Maintenance Director/designee is responsible to ensure compliance.	

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	report indicated the fire alarm was sounded on 9/26/12 at 5:07 p.m. Remarks indicated, "...The incident was determined to be an excessive heat, scorch burns with no ignition." This federal tag is related to Complaint IN00117175. 3.1-51(b)			